Date: [Insert Date]

To: [Insurance Company Name]
Attention: Medical Review/Appeals Department
Address: [Insert Address]
Fax/Phone: [Insert Fax or Phone Number]

Patient Name: [Insert Patient Name]
Date of Birth: [Insert DOB]
Policy Number: [Insert Policy Number]
Group Number: [Insert Group Number]

Subject: Letter of Medical Necessity for Weight Loss Management

To Whom It May Concern,

I am writing to formally request coverage for [Name of Medication/Program/Procedure] for my patient, [Patient Name], who has been diagnosed with Polycystic Ovary Syndrome (PCOS), ICD-10 code E28.2.

The patient presents with the following clinical indicators:

- **Current BMI:** [Insert BMI]
- **Comorbidities:** [e.g., Insulin Resistance, Prediabetes, Hypertension, Irregular Menses]
- **Clinical History:** [Briefly describe failed previous attempts at weight loss or metabolic challenges]

Weight management is a primary medical intervention for PCOS. Excess adipose tissue exacerbates insulin resistance and androgen excess, which are the driving mechanisms of this endocrine disorder. Reduction in body weight is clinically proven to improve ovulation, decrease metabolic risks, and prevent long-term complications such as Type 2 Diabetes and Cardiovascular Disease.

In my professional medical opinion, [Name of Treatment] is medically necessary for this patient to manage the metabolic manifestations of PCOS and prevent further clinical deterioration. Conventional lifestyle modifications alone have proven insufficient for this patient due to the underlying hormonal imbalances associated with their diagnosis.

Thank you for your prompt consideration of this request. Please contact my office at [Phone Number] if you require additional documentation.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]

[NPI Number]
[Practice Name]